SUPREME COURT, U. S.

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1970

No. 702 1

WALTER F. SULLIVAN,

Petitioner,

v.

IRENE RAZA,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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INDEX

Opinions Below 2
Jurisdiction 2
Questions presented 2
Statement 3
Reasons for Granting the Writ 5

AUTHORITIES CITED

Cases

Clark v. Gibbons, 66 Cal 2d 399, 426 P.2d 525 5
Brown v. Keaveny, 117 U.S. App. D.C. 117, 326 F.2d 660 . . . 6
Davis v. Virginian Railway Co., 361 U.S. 358 6
Ewing v. Goode, C.C.S.D. Ohio, 6 Cir., 78 F.442 7
Quick v. Thurston, 110 U.S. App. D.C. 169, 290 F.2d 360 7
Tangora v. Matanky, 231 Cal App. 2d 468 5

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The Petitioner prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the District of Columbia Circuit entered in the above case on June 12th, 1970.

OPINIONS BELOW

The United States District Court for the District of Columbia rendered no written opinion. The opinion of the Court of Appeals for the District of Columbia Circuit has not yet been reported. A copy of said opinion is appended hereto.

JURISDICTION

The judgment of the Court of Appeals for the District of Columbia Circuit was made and entered on June 12th, 1970. On July 24th, 1970, said Court entered an order denying appellee's petition for rehearing. The jurisdiction of this Court is invoked under 28 U.S.C. 1254 (1).

QUESTION PRESENTED

Respondent brought this dental malpractice suit to recover damages for a jaw bone fracture suffered during the extraction of an impacted wisdom tooth. Her case consisted principally of her own testimony and that of the oral surgeon, Dr. Mead, to whom she was referred by petitioner, after the fracture was suspected. Dr. Mead testified as to the accepted methods of widson tooth extraction. Included in his direct testimony were the following question and answer:

> Q. Then if the correct procedure is followed, Doctor, including, as I understand you to say, what amounts to a sort of predetermination about how much force may be applied, can one expect in light of ordinary experience for a fracture to occur?
>
> A. Ordinarily, no.

At the conclusion of the plaintiff's case, the trial court directed a verdict in favor of the defendant. On appeal, the Court of Appeals reversed, holding that the above quoted question "was . . . a proper formulation of a *res ipsa loquitur* inquiry in a malpractice case of the kind before

us" and that the lower court erred in refusing to apply the doctrine of *res ipsa loquitur*.

The questions presented are:

1. Whether the facts in the instant case properly permit the application of *res ipsa loquitur*.

2. Whether the testimony relied on by the Court of Appeals for application of *res ipsa loquitur* did in fact justify use of that doctrine.

3. a) Whether the Court of Appeals has created a novel rule to the effect that evidence of an unsatisfactory result which is statistically rare is sufficient, by itself, in a malpractice suit, to create an inference that the defendant practitioner was negligent.

b) If so, whether this Court, in the exercise of its supervisory powers, should permit such a ruling to stand.

STATEMENT

Respondent commenced to have difficulty with her jaw about six weeks prior to seeing petitioner for the first time. She had previously been to her own dentist who had treated her complaints by filling a tooth, but this did not abate the pain in her jaw. She was first examined by Dr. Sullivan on November 16th, 1966. He first removed the filling previously placed on the possibility that because of its depth it was impinging on the nerve; and, secondly, determined that the cause of the jaw pain was probably a badly impacted wisdom tooth which appeared on X-ray. An appointment was made to have the tooth extracted on November 19th, 1966.

The operation itself was lengthy and difficult and required two administrations of local anesthetic. The respondent related that the dentist appeared frustrated and "hot under the collar" as a result of the lengthy attempt to extract the tooth, but she did not notice any transmittal of this to the manner in which the extraction was conducted.

The petitioner was quoted as saying it was his most difficult extraction in forty years of practice.

In the course of packing the socket, Dr. Sullivan and the patient were aware of a grating sound in her jaw, and although a fracture of the jaw could not be established by X-ray, a clinical diagnosis of fracture was made and Mrs. Raza was referred to Dr. Sterling Mead for treatment.

The specification of negligence against the defendant dentist was limited to the claim that he had used excessive force in the extraction of the tooth.

The substance of Dr. Mead's testimony on the subject of force was that the accepted procedure or surgical technique included a preoperative determination of the limits of permissible force based upon an evaluation of the jaw structure, depth of impaction, etc., as disclosed by clinical and X-ray examination. He further testified that in arriving at a determination of force levels there are no set criteria, that it is "Solely a matter of experience."

In the same vein, the following testimony was elicited from Dr. Mead on direct examination:

> Q. How does one know when one is reaching (the) breaking point or danger point in the process of an extended extraction?
>
> A. I can't give you an intelligent answer to that question. There is no way that you can adequately do so. I think that you are guaged by the severity of the impaction, of the amount of bone, the condition of the bone, and these are intangibles, to answer your question.

Dr. Mead also testified that, given the observance of accepted procedures, a fracture would "ordinarily" not be expected to occur. Earlier he had indicated that the occurence of a fracture is not a "normal pattern but, of course, it's a possibility with removal of any wisdom tooth".

At the conclusion of the plaintiff's case the trial court directed a verdict for petitioner, ruling that the evidence

and common sense indicated force was necessary and how much was a question of judgment and that *res ipsa loquitur* did not apply.

The Court of Appeals reversed, holding that the plaintiff had laid a sufficient evidentiary foundation for the application of *res ipsa loquitur* and the lower court erred in granting the motion for directed verdict.

REASONS FOR GRANTING THE WRIT

The opinion of the Court of Appeals professes to adhere to the universal rule that the necessary prerequisite to the application of *res ipsa loquitur* is proof (either as a matter of common knowledge or through expert testimony) that the injury complained of "ordinarily would not happen in the absence of negligence". This does not mean, obviously, that it is sufficient to simply show that the event is unusual. The proof must establish that it is *more probable* or likely that the injury was the result of negligence rather than some cause for which the defendant is not responsible. *Clark v. Gibbons*, 66 Cal 2d 399, 426 P.2d 525; *Tangora v. Matanky*, 231 Cal App.2d 468.

Nevertheless the question and answer relied on by the Court of Appeals to justify the application of *res ipsa* completely failed to meet this test. All Dr. Mead said was that a jaw fracture "ordinarily" would not occur if accepted procedures were followed. He did not say that if a fracture did in fact occur that it was probable that there had been a departure from standard procedures. He specifically recognized the possibility of a fracture in any extraction of an impacted wisdom tooth and the record is silent as to the relative probability that negligence would be the cause rather than some factor beyond the dentist's control

As a result of an unfortunate lack of precision in the appellate court's analysis, the trial courts of the District of Columbia are confronted with an ambiguous precedent that is subject to the interpretation that the most fundamental evidentiary rule of tort law has been abrogated, i.e. the rule

that the occurrence of an accident does not give rise to an inference of negligence. This is so because the question and answer seized on by the Court of Appeals can be asked in every case in which medical treatment results in an unsatisfactory result, indeed it can be asked in every case involving a personal injury claim. Obviously if "correct procedures" are used it is statistically improbable for any activity (driving, surgery etc.) to result in an accident or injury.

This Court has recognized that *prima facie* proof of malpractice requires two evidentiary steps: evidence as to the recognized standard of the medical community in the particular kind of case, and a showing that the physician in question negligently departed from this standard in his treatment of the plaintiff. *Davis v. Virginian Railway Company*, 80 S.Ct. 387 (1960), 361 U.S. 358. If the holding in the instant case is permitted to stand, plaintiffs in the District of Columbia will naturally contend that the traditional requirements have been abandoned, that all they need do is show an unsatisfactory result and then let the jury speculate as to whether it is due to some negligent act or omission by the defendant doctor.

Petitioner recognizes that he carries a heavy burden of persuasion in arguing that this Court should review a decision affecting local evidentiary rules in the trial of tort cases. The fact that the decision is contrary to the precedent established by this and every other court may not be sufficient in and of itself.

However, there is an additional factor involving public policy which affects every citizen of the District of Columbia. That is the affect of this decision on the availability of essential medical services in the District of Columbia.

Prior to the instant decision, the prevailing rule in the District of Columbia was set forth in the case of *Brown v. Keaveny*, 117 U.S. App. D.C. 117 (1963), 326 F.2d 660, which also involved a jaw fracture in the course of a wisdom tooth extraction. In the *Brown* case there was a dissent by the same judge who was one of the majority on

the divided panel which decided this case. In his prior dissent he noted:

> This protective wall which the law has erected around doctors is founded on the philosophy that if an extraordinary and injurious result "were held to be evidence, however slight, of negligence on the part of the physician or surgeon causing the bad result, few would be courageous enough to practice the healing art, for they would have to assume financial liability for nearly all the 'ills that the flesh is heir to.' " *Ewing v. Goode*, C.C.S.D. Ohio, 6 Cir., 78 F.442, 443 (1897). See *Quick v. Thurston*, *supra* Note 1, 110 U.S. App. D.C. at 172 290 F.2d at 364. This philosophy may have been sound in the nineteenth century before the days of liability insurance. But today, with insurance, financial responsibility is not one of the dangers to the doctor in a malpractice suit.

The obvious fallacies in this observation are the assumptions that liability insurance carriers will continue to provide malpractice coverage regardless of the exposure created by an explosion in the number of suits filed and an expansion of liability by novel legal theories; or, if coverage is available, that doctors (and indirectly their patients) will be able to afford the continually escalating premium charges.

The subject of the affect of malpractice litigation on the public welfare has recently been explored by Congressional Committee and the results of this inquiry are set forth in detail in the publication *Medical Malpractice: The Patient Versus The Physician*, a study submitted by the Subcommittee on Executive Reorganization to the Committee on Government Operations of the United States Senate (November 20th, 1969).

If the courts are going to use the existence of liability insurance to justify expansion of concepts of liability, it is only fair that judges acquaint themselves with the economic facts of life. Some of the facts disclosed by the aforementioned congressional study are:

a) In recent years the insurance companies have suffered large underwriting losses in the field of malpractice insurance.

b) As a consequence of those losses insurance companies have been forced either to abandon this type of insurance or to raise premiums by hundreds of percent.

c) In some areas of the country there is already a definite problem with respect to the availability of insurance protection at any price.

d) No physician can afford to take the chance of practicing without insurance coverage.

e) The rising costs for insurance protection are passed on to patients in the form of higher medical fees, health insurance premiums, etc.

(The foregoing conclusions appear in various contexts throughout the Study; it does not appear that any of the witnesses who testified before the committee and/or submitted written material would contest the accuracy of these statements as summarized herein.)

The inquiry by the Congressional subcommittee also disclosed that mushrooming malpractice litigation may have an unfortunate affect on the manner in which medicine is practiced. Although all doctors naturally prefer to believe that their medical judgments are based on what is best for the welfare of their patients, numerous informed witnesses expressed the opinion that fear of potential litigation may play a substantial role in medical decisions. The commonly cited possibilities included the ordering of additional diagnostic tests which are not really necessary and a reluctance to make use of extraordinary medical or surgical procedures which are reasonably necessary for the medical welfare of the patient but which also involve unavoidable risks. If the threat of a law suit does result in a significant amount of unnecessary and expensive testing, or in an ultra-conservative approach to treatment, it is again the patient who pays the penalty.

In discussing some of the practical and social ramifications of malpractice litigation, petitioner does not mean to imply that the medical profession should constitute a privileged class immune to any liability for the results of its actual negligence. It is suggested, however, that judicial liberalization of traditional fault/liability concepts, and the evidentiary and procedural rules encompassing them, should not be predicated on the superficial notion that "the insurance company will pay."

If the instant case means, as the Court seems to say, that if standard procedures are used and an untoward result occurs, an inference of negligence is thereby created, the affect on malpractice litigation in the District of Columbia will obviously be tremendous. It can be safely predicted that such a development will not pass unnoticed by the insurance industry. One or more of several eventualities will then take place. Insurance carriers may decline entirely to write malpractice insurance. (Only a very limited number of companies still offer such coverage.) If this drastic step is not taken, it is certain that companies will (a) become even more selective and quicker to cancel policies and (b) further raise premiums to meet the higher costs incident to expanded liability.

The reaction of doctors is likewise predictable. The older practitioners may elect earlier retirement. Others will search out "greener pastures" in the more favorable environment of the suburbs. New practitioners will be dissuaded from locating their practice in the District of Columbia. The remaining physicians will raise their fees to meet increased overhead expenses. The public will be left with reduced health services and higher costs.

Petitioner submits that in casting aside the traditional requirements of proof in a malpractice case, the Court of Appeals has not only made bad law, but has also worked a disservice upon the citizens of the District of Columbia. It seems particularly inappropriate for the United States Court of Appeals to create such a dubious precedent when the

Congress has at last recognized the right of District of Columbia residents to have their own independent court system subject only to review by this Court. (Title 11, District of Columbia Code, as amended by District of Columbia Court Reorganization Act of 1970.)

CONCLUSION

For the reasons set forth above, it is respectfully submitted that this petition for a writ of certiorari should be granted.

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Of Counsel:
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United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 23,420

IRENE RAZA, APPELLANT

v.

WALTER F. SULLIVAN

Appeal from the United States District Court
for the District of Columbia

Judgment entered this date ←

Decided June 12, 1970

Mr. Charles A. Dukes, Jr., for appellant.

Mr. Walter J. Murphy, Jr., for appellee.

Before WILBUR K. MILLER, *Senior Circuit Judge*, WRIGHT and MCGOWAN, *Circuit Judges*.

MCGOWAN, *Circuit Judge*: Appellant brought this negligence suit in the District Court to recover damages for a jaw bone fracture suffered during the extraction of a wisdom tooth. The matter went to trial before a jury, but at the close of appellant's case the judge directed a verdict for appellee, the dentist who had extracted the tooth. For the reasons hereinafter appearing, we reverse the judgment of the District Court and remand the case for a new trial.

I

Appellant's case consisted principally of her own testimony, and that of the oral surgeon to whom she was referred by appellee after the jaw fracture was discovered. Appellant testified that she kept a dental appointment with appellee for the purpose of having the wisdom tooth pulled. At the end of an unusually prolonged and apparently difficult extraction, in the course of which appellee assertedly exhibited signs of growing impatience and frustration, appellant sensed a snapping sound in her jaw.[1] By the next day she felt considerable pain and immobility in the affected area, and returned to appellee who concluded that there might have been a fracture. He sent her to the oral surgeon, who confirmed this diagnosis.

The oral surgeon, Dr. Mead, a conceded expert, then testified for appellant as to the accepted methods of wisdom tooth extraction. He said that dentists will, as appellee did herein, first x-ray a patient's jaw in order to make a prior determination of the force level which should not be exceeded. Then, dentists generally break the tooth and remove its pieces, or, as was done here, cut around the tooth and raise it with an "elevator." During these procedures, dentists will use their experience and "sense of feel" as a check against exceeding the permissible force level. Acting by reference to this prior determination is an important

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[1] Appellant's testimony was that, as the extraction effort proceeded, appellee remarked that it was giving him the most difficulty he had had "in forty years." She also said that, as time wore on into the second hour, appellee was "getting impatient," "more and more upset," "excited, heated," "red in the face," and "breathing heavily." When the tooth finally came out, she "felt as though my ear had been wrenched out;" and appellee characterized the tooth as "really a monster." Appellant then "heard a crack, and I looked up and I realized [appellee] was bending over me, and I said 'Doctor, what was that?' And he said, 'I don't know.' "

part of the accepted procedure. Dr. Mead testified that "[i]f you are following accepted procedures you don't use excessive force." Dr. Mead opined that an intentional use of excessive force would be negligent, but would not state an opinion as to whether an accidental use of excessive force would be. He also testified that wisdom tooth extractions do not, if the accepted procedures are being observed, normally result in jaw bone fractures.[2]

At the close of appellant's evidence, appellee moved for a directed verdict and indicated his purpose to stand upon that motion if it were denied. In support of the motion, it was mainly argued that appellant had adduced no evidence of any standard relating to the extraction of a wisdom tooth, nor of any departure from such a standard if one be assumed to have been shown. This contention appeared thereafter to develop into a claim that appellee had at most been shown to have made a mistake in judgment, in the exercise of which, so it was said, medical men are legally immune from liability.

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[2] The question by appellant's counsel which Dr. Mead was permitted to answer on this score was:

> "Q. Then if the correct procedure is followed, Doctor, including, as I understand you to say, what amounts to a sort of predetermination about how much force may be applied and should be applied, can one expect in light of ordinary experience for a fracture to occur?
>
> "A. Ordinarily, no."

Earlier in Dr. Mead's direct examination, this colloquy occurred:

> "Q. Doctor, have you an opinion as to whether or not a broken jaw and or nerve damage is of such a character as in the light of ordinary experience is likely to occur as a result of negligence in extraction?
>
> "MR. MURPHY: If Your Honor please, I object.
>
> "THE COURT: I'm afraid I will have to sustain the objection."

Appellant in response appeared to assume that reliance upon *res ipsa loquitur* was foreclosed by the decision of this court in *Brown v. Keaveny*, 117 U.S.App.D.C. 117, 326 F.2d 660 (1963). Her contention was that the testimony given by her as to appellee's agitation and impatience over the lengthy resistance of the tooth to his efforts was evidence from which the jury could infer that appellee had improperly exceeded the pre-determined force level referred to in Dr. Mead's testimony as an essential element in the accepted procedure for wisdom tooth extraction.

The trial court, in granting the motion, characterized our *Brown* decision as holding in malpractice cases that "the issue may not be resolved by the jury without the aid of expert opinion." It was this case, however, which caused it to say that it would deny the motion but for the seeming unavailability in this jurisdiction of the doctrine of *res ipsa loquitur* in medical malpractice cases:

> "I have given consideration to this motion . . . and if I were free to do so I would rule that a res ipsa loquitur applies in the sense that it raises an inference of negligence and calls on the defendant for an explanation of why this unusual occurrence took place of breaking the plaintiff's jaw when she was there to have a tooth extracted, but I do not feel free, in the light of the decisions of the Court of Appeals, to make such a ruling."

II

On this appeal, in addition to arguing that there was sufficient evidence of specific negligence to counter a directed verdict, appellant reverts to the concept of *res ipsa loquitur*. This last takes the form of a complaint that the trial court erred in sustaining the defense objection to the question first asked of Dr. Mead as to whether a broken jaw "in the light of ordinary experience is likely to occur as a result of negligence in extraction." Note 2, *supra*. Whether this was error or not seems to us essentially un-

important since Dr. Mead was later permitted to answer the inquiry as to whether, given the observance of accepted procedures, it may be expected "in light of ordinary experience for a fracture to occur." His answer was: "Ordinarily, no." Note 2, *supra*.

This second question was, in our view, a proper formulation of a *res ipsa loquitur* inquiry in a malpractice case of the kind before us.[3] Appellant cannot, therefore, be said to have been foreclosed from eliciting the answer she sought. We do not, thus, consider that reversal is necessitated solely because Dr. Mead was not permitted to answer the earlier question.

Where the trial court did err was in professing to believe that, in this jurisdiction, *res ipsa loquitur* can play no role whatsoever in medical malpractice cases. The court explicitly stated that the position it took was dictated by our decision in *Brown*, and it characterized that case as stating "very clearly that in a malpractice action where the question turns on the merits and performance of scientific treatment, the issue may not be resolved by the jury without aid of expert opinion."

Brown was, however, a case in which no expert opinion

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[3] There is, obviously, no rule that every medical malpractice case must have expert testimony as a basis for the invocation of *res ipsa*. The absent-minded nurse or surgeon who leaves a sponge or surgical tool in the patient's body is vulnerable to purely lay opinion that this is below the prevailing standard of care. *See* Christie v. Callahan, 75 U.S.App.D.C. 133, 136, 124 F.2d 825, 828 (1941). But a case like the one before us, involving the exercise of professional skill and judgment, is a far cry from the barrel falling from the upper floor of the warehouse on the head of the innocent passer-by in the street, which was what was involved in the case commonly thought to be the first articulation of the *res ipsa* doctrine. Byrne v. Boadle, 1863, 2 H. & C. 722, 159 Eng. Rep. 299.

was adduced by the plaintiff.[4] What the majority in that case held was that, at least in some classes of malpractice cases, it is not enough for a layman to prove merely the fact of injury and then to invoke *res ipsa loquitur* upon an assumption that it is common knowledge that the injury would not have occurred absent negligence. This is so because in the medical field doctors cannot guarantee satisfactory results in all cases even where they are observing accepted medical procedures.

In our later case of *Smith v. Reitman*, 128 U.S.App.D.C. 352, 389 F.2d 303 (1967), Judge (now Chief Justice) Burger, speaking for the court, was at some pains to dispel the notion "that the doctrine [of *res ipsa loquitur*] can never be available in malpractice cases." That was a case also involving a jaw injury incident to a dental operation. Although the plaintiff there did offer an expert witness who voiced the opinion that, because injury resulted, a mistake must have been made, the expert witness rested largely upon that bare assertion and gave no explication of accepted procedures or how negligence could on occasion intrude into those procedures. The court concluded that a record in that condition "does not create the basis for invoking *res ipsa loquitur*."

The expert testimony brought out by appellant in the case before us if of quite a different order. Dr. Mead testified at length and in detail as to the accepted procedures for effecting the extraction of a wisdom tooth with due care

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[4] Even in *Brown* there was no direction of a verdict at the end of the plaintiff's case. The allegedly errant dentist testified in his own defense, but, as Judge Wright pointed out in his dissent, he supplied little, if any, information about accepted procedures or the degree to which he observed them. His testimony was heavily preoccupied with his wonderment that the injury should have occurred at all, thereby emphasizing the extraordinary nature of the event.

for the avoidance of the kind of injury which occurred here. Those procedures were said to include a pre-operation survey for the purpose of fixing the level of force which under no circumstances should be exceeded in the physical extraction itself. It was his professional opinion that, if these accepted procedures were followed, a jaw fracture would not "ordinarily" happen.[5]

We ourselves have said, in common with other authorities, that "ordinarily" is the key word in the concept of *res ipsa loquitur*. In *Quick v. Thurston*, 110 U.S.App.D.C. 169, 172, 290 F.2d 360, 363 (1961), we denominated that concept to be "a common sense rule which allows an inference of negligence where the occurrence complained of *ordinarily* [emphasis supplied] would *not* happen in the absence of negligence." *See* Prosser, *Torts* § 42, and Judge Wright's dissenting opinion in *Brown*. Dr. Mead's testimony expressly embraced the possibility, therefore, that appellant's injury could have been the consequence of negligence in the sense that appellee, in the execution of the applicable accepted procedures, may have deviated from them. That this deviation be thought to have been intentional is not, in our view, essential to culpability. The surgeon who, without in-

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[5] The dissenting opinion in *Brown*, where no expert witness testified for the plaintiff, was premised in considerable degree upon "what has been referred to as the conspiracy of silence—the refusal on the part of members of the profession to testify against one of their own [footnote omitted] for fear that one day they, too, may be defendants in a malpractice case." *See* Note, *Overcoming the "Conspiracy of Silence": Statutory and Common-Law Innovations*, 45 MINN. L. REV. 1019 (1961); Note, *Medical Malpractice—The Medical and Legal Aspects of the Post-Prostatectomy Urinary Incontinence Suit*; 17 BUFFALO L. REV. 471, 487-90 (1969). Whatever may be the validity of that premise generally, it was not visible in the record before us. Dr. Mead, to whom appellee referred appellant for treatment, testified at length for appellant.

tending to do so, lets the knife slip and cuts too deeply may still be liable for malpractice.

Appellant's testimony is suggestive, albeit far from conclusive, that there may have been a deviation of the kind contemplated by Dr. Mead. We do not, of course, mean to suggest that this record points inescapably towards liability. What we do say is that appellant had shown enough to defeat a motion for a directed verdict at the close of that showing. It was the trial court's instinctive preference that appellee should be called on "for an explanation of why this unusual occurrence took place."[6] We agree, and our difference with that court is only over its feeling that it had no room to indulge that preference. We reverse and remand so that it may do so.[7]

It is so ordered.

Wilbur K. Miller, *Senior Circuit Judge*, dissents.

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[6] The dissenting judge in Smith v. Reitman, *supra*, where no defense testimony was received, concluded alternatively that "[A]t least the defendant should have been put to proof."

[7] We, of course, do not speculate as to what the situation may be at the close of all the evidence. Defense testimony that due care was used will not in itself eliminate the inference rooted in the probabilities of human experience. Classic *res ipsa* theory contemplates that a defense showing can be such, however, as to eliminate that doctrine from the case, leaving the trial court under the necessity of dealing with the state of the evidence unaided by any inference deriving from it alone. *See* Restatement (Second), Torts, § 328D, comments n, o (1965).